LHI LOGISTICS HEALTH INCORPORATED®

Innovative Healthcare Solutions.

PATIENT AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION TO THIRD PARTY

Patient's Name: _____
(Last) (First) (Middle)
Date of Birth: _____ Phone (___)_____

Address: _____
(Street) (City) (State) (Zip Code)

Please request/check all that apply:

I authorize _____ to disclose medical information about my:
*Insert **name of Clinical Center***

☐ World Trade Center Medical Monitoring Program physical examination records

☐ World Trade Center Medical Monitoring Program mental health questionnaire/evaluation

☐ World Trade Center Medical Treatment Program visit(s)

Records to be disclosed ☐ do include ☐ do not include HIV-related information (check one).

To: Logistics Health Incorporated
328 Front Street South
La Crosse, Wisconsin 54601
Phone # 877-498-2911 Fax# 608-793-2964

Reason for disclosure ☐ Patient Request ☐ Other

We will not condition treatment or payment on whether you sign this authorization. However, if you refuse to sign we will not release your records.

I understand that this authorization is valid for one year from this date or until _____ and may be revoked by me at any time except to the extent _____ has already taken action based on my authorization.
name of clinical center

SPECIFIC UNDERSTANDINGS

I understand that this consent may include disclosure of Alcohol and Drug Abuse records and/or Psychiatric records and or HIV-related information (indicating that I have had an HIV-related test, or have HIV infection, HIV-related illness or AIDS, or that could indicate that I have been potentially exposed to HIV).

If I am authorizing the release of HIV-related information, the recipient(s) is prohibited from redisclosing any HIV-related information without my authorization unless permitted to do so under federal or state law. I also have a right to request a list of people who may receive or use my HIV-related information without authorization. If you experience discrimination because of the release or disclosure of HIBV-related information, you may contact the New York State Division of Human Rights at (800) 523-2437/(212) 480-2493 or the New York City Commission on Human Rights at (212) 306-7450.

By signing this authorization form, I am authorizing the use or disclosure of my protected health information as described above. This information may be redisclosed if the recipient(s) as described on this form is not required by law to protect the privacy of the information, and such information is no longer protected by federal health information privacy regulations.

Patient
Signature: _____ Date: _____

Personal Representative
Signature: _____ Print Name:_____

Authority: _____ Tel. No. _____

Address: _____ Date: _____
(Personal Representative to sign only if patient is a minor or incompetent).

To request records or to revoke authorization, send a written request to the address at the top of this page.

Revised 08/19/2008 CC